Cascadia Behavioral Healthcare

🞎 Check if one-time only Release

🞎 Check if PCP Release

🞎 CBHC is REQUESTING Records

🞎 CBHC is SENDING Records

🞏 Keep Release on FILE for future use

**AUTHORIZATION TO USE / EXCHANGE HEALTH INFORMATION**

*Tigard Adult Respite, 14127 SW 114th Avenue, Tigard, OR 97224 (o)503-777-2278 (f)503-747-4387*

**Client's Name:**

Last First Middle

**DOB: Home Phone**

**Address** N/A

Address City State Zip

I authorize the following individual or agency to provide / exchange the following information with **Cascadia Behavioral Healthcare:**

Name Phone Fax

Address City State Zip

*(If records cannot be provided at no charge, do not fill request)*

**\_\_\_\_\_***(🡸****By Initialing here)*****I AUTHORIZE THIS RELEASE OF INFORMATION TO INCLUDE** any information about **MENTAL HEALTH** treatment or evaluation, to include information pertaining to sexual assault, child abuse and neglect, hospital records, medical records, laboratory reports and school records.

*\_\_\_\_\_(🡸****By Initialing here)*** **I AUTHORIZE THIS RELEASE OF INFORMATION TO INCLUDE** any **ALCOHOL / DRUG / GAMBLING** diagnosis, treatment, and prognosis information. I understand that any disclosure made is bound by Part 2 of Title 42 of the Code of Federal Regulations (CFR) governing confidentiality of alcohol and drug abuse patient records. **Recipients of this information may re-disclose it only with my written consent** or as permitted by 42 CFR Part 2.

*\_\_\_\_****(🡸 By initialing here*)** **I AUTHORIZE THIS RELEASE OF INFORMATION TO INCLUDE** any **HIV (AIDS)** diagnosis, treatment, and prognosis information.

**[This Box MUST be Completed for All Requests for Information]**  **Check here for VERBAL information exchange only**

**CLIENT: Please INITIAL after “How Much” and “What Kind or Description” to authorize quantity / type of information to be disclosed:**

**HOW MUCH** information is to be disclosed: \_\_\_\_Last 6 mo \_\_\_\_Last 1 Yr \_\_\_\_Last 2 Yrs \_\_\_\_All \_\_\_\_Other:

**WHAT KIND or DESCRIPTION** of information is to be disclosed:

\_\_\_\_Treatment Plan \_\_\_\_Assessment \_\_\_\_Progress Notes / Reports \_\_\_\_Med Orders/Med Notes \_\_\_\_Psych Eval \_\_\_\_Lab Work/Test Results \_\_\_\_Discharge Summary \_\_\_\_Other:

**PURPOSE OF DISCLOSURE:** I authorize Cascadia to use / exchange my health information noted above for the **purpose of evaluation, treatment planning, service coordination, monitoring, and treatment referral**. *If this Authorization is to be used for additional purposes, or purposes other than those noted here, please indicate below:*

**\*\*\*I understand Cascadia Behavioral Healthcare cannot guarantee information will not be disclosed if the information is released to an organization NOT SUBJECT to Federal and State laws.\*\*\***

**TERM:** I understand that **I may revoke this authorization at any time** except to the extent that action has been taken in reliance upon it. I understand that I may refuse to sign this authorization, and that refusal to sign this authorization may affect Cascadia’s ability to coordinate and obtain services. Without my express revocation, **this Authorization will expire 1 year from the date of signing** or shall remain in effect for the period reasonably needed to complete the request, unless otherwise specified below:

This Authorization is limited to the following time period or until the following event occurs:

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and exchange of my health information. By my signature, I hereby, knowingly and voluntarily authorize Cascadia to use or exchange my health information in the manner described above.

**Signature of Client** **Date**

***Note:*** *If Client is a minor or is otherwise unable to sign this Authorization, obtain the following signature:*

Signature of Authorized Personal Representative Relationship to Client Date